CHAPTER 1

Introduction

Basic Truths about Military Stress, Trauma, and Posttraumatic Stress Disorder

It is an unfortunate truth that our armed conflicts over the years continue to advance our understanding of stress and trauma. The prolonged and simultaneous hostilities in which we have been embroiled of late have created an unusual situation in which service members have returned repeatedly to war and, in some cases, have returned years later to fight in the same places. The implications of sending an operationally fatigued set of warriors back to the fight are still being identified. At no time in our history has our understanding of military service, deployment, operational, and combat stress been more critical.

Our intense focus on posttraumatic stress disorder (PTSD) seems to have made the notion of PTSD synonymous with the experience of veterans. This has had benefits in that resources have been allocated for wartime stress disorders, policies have been implemented to protect service members with posttraumatic stress symptoms, and substantial research has been conducted into PTSD. However, linking military experience with PTSD has had some unintended consequences as well. It may be useful, in the context of treating service members and veterans or of simply being a good friend, family member, or neighbor, to consider some truths about military stress, trauma, and PTSD.

This is not the first time that we have struggled with this similar constellation of variables regarding wartime trauma.

PTSD represents the current terminology in a long line of conceptualizations of wartime psychological sequelae. Our historic struggles with

the psychological aftermath of war is a constant theme throughout this volume because there is much to learn from prior wars. Even the political and media focus on veterans' issues postdeployment are not new, and we are again having to learn to navigate this landscape for the maximum health of veterans. Similar challenges were seen in World War II, for example, when veterans were also big news. Unfortunately, not all of that news was beneficial or accurate. Pratt (1944), writing at the end of the war regarding transitioning service members from soldiers back to productive civilians, wrote:

> Veterans are already the most important news item in the national scene, short of the war itself. The problem now is not the amount of publicity, but rather the kind of publicity that will help toward meeting veteran's needs as adequately and in as orderly a way as possible. The importance of what is said and how it is said cannot be overrated because publicity will influence the attitudes of the general community, the veteran's family, his employer, his associates, and himself. (p. 225)

Pratt (1944) went on to say, pertaining to news stories about the numerous services that were springing up around the country for veterans:

> Chief among these, in the initial planning stages, is the "Veterans Seen as Big Problem" type of headline and story. A great many newspaper stories printed so far could not fail to lead the community to view with alarm, and with not a little confusion, the prospect of hundreds of khaki-shirted veterans coming home with "problems." (p. 226)

We can learn much from looking back at our past conflicts, descriptions of wartime stress reactions, and the successes and failures we had then. We can also learn much from the evolving conceptualization of stress reactions. Chapter 2 provides a timeline of our understanding of military stress and posttrauma diagnoses. Within these classifications, symptom presentations, and definitions, you will see similar struggles, the impact of societal views, and whether the terms and approaches were/are beneficial.

PTSD is an amorphous concept.

PTSD is an unusual diagnosis. No symptom of PTSD is specific to PTSD, and two people, both with a diagnosis of PTSD, may not actually share any of the same symptoms. In fact, the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association,

2013) provides for 636,120 symptom combinations that can result in the diagnosis of PTSD, as compared with 79,794 from the prior version of the manual (Galatzer-Levy & Bryant, 2013). Thus PTSD has become a blanket descriptor category that may have limited utility in getting at the heart of the clinical presentation of any given service member or veteran.

Another related problem may be that the notion of trauma itself seems to have become less defined, the symptoms have expanded dramatically, and although "exposure to actual or threatened death, serious injury, or sexual violence" (American Psychiatric Association, 2013, p. 280) is a requirement for the diagnosis, some patients are receiving diagnoses of PTSD following common human events, such as getting fired or divorced (Ghaemi, 2015). In considering the symptoms of PTSD, Robinson and Larson (2010) compared samples of individuals who had experienced traumatic events (e.g., physical or sexual assault) with those who had experienced common stressful life events (e.g., relationship stress, problems at work or school) and found that both types of events can result in what are currently considered posttraumatic stress symptoms. Galatzer-Levy and Bryant (2013) note that because many PTSD symptoms are common reactions to normal stressors it is difficult to differentiate those with a pathological response from those without. Snedkov (2011) stated, "Diagnoses of protracted post-traumatic stress disorder (PTSD) are beginning, in some scientific publications, to share the fate of the neuroses" (p. 161), and he described PTSD as "no more than a syndrome—a typical nonspecific pathological state which can be encountered in the structure of a whole group of different mental disorders" (p. 162).

The ambiguity of the diagnosis complicates the care of our military. While there are great treatments for some posttraumatic symptom constellations, we continue to struggle with the increasingly nebulous concept of PTSD. Chapter 2 provides further information on the evolution of the concept of PTSD.

Although PTSD is often a necessary focus of this work, there are other classifications of military trauma and stress that can be clinically more on target.

It is important to keep in mind that PTSD is not always pertinent to specific military populations. The Gulf War provides us with a striking example of the military's need for effective terminology for medical and psychiatric conditions in order to meet unique needs of the military. During the Gulf War, there was a need to develop new nomenclature (e.g., Gulf War syndrome), as the DSM provision of PTSD did not capture that war's constellation of psychological symptoms. PTSD is one potential outcome,

but it is by far not a universal experience, even when service members develop psychological health problems as a direct result of military traumas or stressors.

If we define a military stress reaction as that juncture at which external events exceed a service member's ability to effectively maneuver or cope, it is apparent that there is a range of responses that may ensue. Most of these are not considered clinical or pathological, and even when problems do meet the threshold to be considered clinical disorders, PTSD is not always an adequate conceptualization. Combat stress, operational exhaustion, and adjustment problems, as examples, are typically normal reactions to military and wartime stressors and require a different approach from that needed for a traditional clinical disorder. Chapters 3 and 4 explore military stress reactions.

PTSD is not the most common mental health challenge for service members.

Even for those who are having challenges following a deployment, another military experience, or other problems, PTSD is not the most common issue. As previously stated, the current focus on PTSD fails to integrate resolvable and transient adjustment, stress, and exhaustion reactions. In addition, the narrow focus on PTSD detracts attention from common postdeployment problems such as reintegrating into the civilian world, substance misuse, depression, anxiety, grief, guilt, sleep difficulty, and relationship problems, and may create an environment that is difficult to navigate for veterans, families, and providers alike. The overemphasis on PTSD obscures the complexities of stressors and other experiences encountered by service members and makes it difficult to appropriately assess, diagnose, treat, and support them. When working with active duty service members, it is important to remember that the most common mental health diagnoses are adjustment disorders, followed by anxiety disorders, depressive disorders, and insomnia (Defense Health Agency, 2017). Chapters 3 (military stress reactions), 4 (risk factors), 7 (suicide risk, substance abuse, sleep problems, depression, grief, and emotional numbing), and 8 (concussion) explore other descriptors, postdeployment challenges, and diagnostic possibilities.

Most service members will not develop PTSD, even those who engaged in heavy combat.

The concepts of "combat and operational stress" and PTSD have become profoundly political. Although this politicization has allowed media

coverage and effectively promoted increased allocation of resources for those with clinical disorders, these reports have also had the unintended consequence of creating a significant misunderstanding of normal military stress reactions. Service members may emerge from deployments and wartime situations with some variant of combat or operational stress, but most do not go on to develop PTSD or other mental health diagnoses.

Misunderstanding that can add to the difficulties service members face upon returning from deployment. Take the following example. Upon returning home from Afghanistan, a friend of mine was reunited with her family. The first question they asked her as she stepped off the bus from the airstrip was, "Did you get the PTSD?" She wondered how PTSD could be the one thing on the forefront of her family members' minds. Unfortunately, this type of belief may also be adopted by the individual service member.

Shephard (2004) expressed serious concern that we have medicalized the human response to stressful situations and, in turn, have created a culture of trauma, thus undermining the general capacity of individuals to resist trauma. Moloney warned in 1949 that "the psychological nonpolitical approach to the psychiatric casualty . . . is imperative." Frances (2013) believes that PTSD is overdiagnosed so that veterans can receive financial benefits, but at a cost to the diagnosed individuals. "Many returning vets from Iraq and Afghanistan are having trouble landing jobs because of the stigma associated with their diagnosis of PTSD. And over-diagnosis distorts allocations across the system, reducing resources and benefits for those who most need them" (p. 85). Consider the following example.

CASE 1.1. The Soldier Who Wanted Marital Therapy

The soldier had survived a terrorist bombing while serving in the military and had processed this experience in a way that enabled him to become a successful police officer following military service. He had no mental health complaints. Several years after leaving military service, however, he sought therapy at the VA secondary to marital problems. He was flagged for a PTSD evaluation. When he explained he just wanted marital therapy, the person conducting triage told him that because of his military experiences he would easily meet criteria for PTSD and financial benefits. He was placed in a position of having not only to argue that he didn't have PTSD but also to turn down money. After being required to undergo an evaluation to access marital therapy, he was not given a diagnosis of PTSD, but he felt he was put in the unnecessary and uncomfortable position to prove it.

Beyond interfering with possible future employment, sending a message to a veteran that he or she is ill when he or she is not propagates a view of him- or herself as damaged and may deprive society of the benefits

of that veteran's participation in the community. For the veteran in Case 1.1, would a diagnosis of PTSD have harmed his ability to continue in the police force? There are many second-order effects of these diagnoses. Even in the educational system, college faculty are wary of their abilities to effectively teach veterans of the current wars (Barnard-Brak, Bagby, Jones, & Sulak, 2011).

Given the inception of the term *PTSD* following the Vietnam War, our understanding of the prevalence of PTSD begins with Vietnam veterans. Long-term follow-up reveals that among Vietnam veterans, 18.7% developed war-related PTSD and that at 12 years post-Vietnam, 9.1% had active symptoms (Dohrenwend, Turner, Turse, Adams, Koenen, & Marshall, 2006). In active-duty U.S. personnel, 13.5% of soldiers, 10% of Marines, 4.5% of sailors, and 4% of airmen had a diagnosis of PTSD in 2012 (Institute of Medicine, 2014), and these percentages dropped precipitously by 2016 (Defense Health Agency, 2017) due to significantly decreased combat action and deployments overall. Kok, Herrell, Thomas, and Hoge (2012) examined pre- and postdeployment prevalence rates of PTSD in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) service members and found that 3% met criteria for PTSD prior to deployment, 5.5% met criteria postdeployment, and, when looking at infantry specifically, 13.2% of these service members met criteria for PTSD postdeployment.

Concussion and combat stress share the same symptoms.

PTSD is an amorphous concept. To compound the challenge of assessment further, mild traumatic brain injury (mTBI), better referred to as concussion, and combat stress/PTSD also share most symptoms. And in fact many of the treatment strategies currently used for PTSD match those that are successful for concussion. Understanding the symptoms and course of both concussion and combat stress are necessary ingredients of developing precise treatment approaches that will yield symptom resolution. See Chapter 8 for more on the interplay and interventions for concussion and combat stress.

Military stress reactions are partially preventable and highly treatable.

Our knowledge of prevention and early intervention strategies, risk factors, and protective factors has progressed over time, and in the past few decades, the treatment of posttraumatic disorders has been refined. Integrated prevention strategies, which are primarily focused on military

leadership and secondarily focused on mental health strategies, continue to evolve to address the wide variety of military stress responses (see Chapter 10). The U.S. Departments of Defense (DoD) and Veterans Affairs (VA) have been able to identify multiple treatments that are effective for the treatment of depression, suicide risk, substance use disorders, and PTSD in active duty service members and veterans (see Chapters 7 and 9). Accessing this treatment continues to be a challenge due to both systemic issues (Center for Deployment Psychology, 2015) and other barriers to care, such as stigma (see Chapter 5). But when it is provided, state-of-the-art care keeps PTSD from becoming a chronic, impairing disorder.

Military service is beneficial both to those who serve and to the rest of us.

Contrary to widespread assumptions, veterans generally are not pathologically affected by their military service (see Chapter 11). Veterans as a group are better citizens and play major roles in strengthening our civilian communities. For example, 73.8% of veterans vote, compared with 57.2% of nonveterans (Tivald, 2017). A 2015 study comparing veterans with nonveterans reported five key findings (Tivald & Kawashima-Ginsberg, 2015): (1) veterans volunteer in their communities 25% more than nonveterans; (2) veterans are more likely to "attend community meetings, fix problems in the neighborhood, and fill leadership roles in community organizations" (p. 5); (3) more veterans are involved in civic groups (17.7%) when compared with nonveterans (5.8%); (4) "veterans vote, contact public officials, and discuss politics at significantly higher rates than their non-veteran counterparts" (p. 5), and (5) more veterans are trusting of their neighbors (62.5%) when compared with nonveterans (55.1%) and are more likely to talk with and do favors for their neighbors. Importantly, veterans are less likely than nonveterans to engage in violence or to be incarcerated for any type of crime (Sreenivasan et al., 2013). Over the course of their military experience, veterans develop a worldview that can only be beneficial to their communities, bringing fresh skills, understanding, and healthy perspectives.

Veterans are *less* likely to engage in violence than nonveterans.

Of course, no foolproof means exist to prevent or cure posttraumatic disorders. And, indeed, some of our veterans need social, vocational, financial, and mental health support. However, this does not outweigh veterans' potential contributions to their families and to society in general.

In our current state of the science regarding reactions to war, we have at our disposal a growing list of treatments with an evidence base

proving that they work. We know how to assess a military member with structured interviews, specific military components, psychological testing, collateral interviews, and record review (see Chapter 6). We have developed an understanding of the cultural framework needed for providers to work with veterans successfully. We are beginning to maximize peer supports that have great promise in assisting transitioning or struggling personnel. Destigmatization efforts appear to be paying off, as military members are more likely to seek care now than ever before. These developments represent huge successes.

The main message of this book is that when a service member develops psychological symptoms subsequent to military stressors or trauma, experiencing such symptoms is neither abnormal nor permanent. Most important, we have the tools to address these reactions. Let's look at another case before diving into the book.

CASE 1.2. The Soldier Who Was Successfully Treated for PTSD

The soldier returned from his third combat deployment weary and having experienced multiple traumas, including the deaths of two close friends, four improvised explosive device (IED) attacks, two blast concussions, and several firefights. After each deployment, he had increasing difficulty reintegrating into his family, until he and his wife weren't sleeping in the same room anymore and she began talking about divorce. He was continuously disturbed by nightmares and started drinking excessively nightly to be able to fall asleep, which interfered with his concussion recovery. The drinking increased, and he began avoiding his military friends and started making significant mistakes at work. A few months later, after violating safety rules on the firing range, he was command directed for a mental health evaluation. During the course of his evaluation, it became clear that he met criteria for an alcohol use disorder and PTSD. Given the severity of his drinking, he was placed in residential substance treatment, which addressed his alcohol use and began to address his posttraumatic symptoms. After discharge, he continued in aftercare for his alcohol use disorder and went to outpatient mental health treatment, was supported by his command, and eventually completed a course of cognitive processing therapy with extra focus on his nightmares. His concussion symptoms resolved over this time period. As his treatment progressed, his wife agreed to reconsider divorce—and with his sobriety and control of his posttraumatic symptoms, he returned to work with no restrictions on his duties. Finally, he and other members of his unit formed a regular time every week to socialize to ensure peer support.

This soldier's outcome is not rare. We just hear less about the cases that go right. This soldier had a reaction to unspeakable trauma, a reaction

that no one would consider abnormal. He was provided empirically based treatment for both his substance use and posttraumatic symptoms, and, with the support of his command, he returned to duty with a stronger marriage and better social supports. These are appropriate and realistic targets for treatment. Through the timely and accurate identification of problems, cultural competence, consideration of history and military experience, and use of empirically based treatments, we can meet the psychological health needs of our nation's warfighters.

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